TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION
GENERAL INFORMATION

Requestor Name
TEXAS HEALTH INJURY 1 OF DALLAS

Respondent Name
WAL MART ASSOCIATES INC

MFDR Tracking Number
M4-15-3834-01

Carrier's Austin Representative
Box Number 53

MFDR Date Received
July 23, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Eval is medically necessary prior to requesting and rendered preauthorization for individual psychotherapy which was preauthorized and deemed medically necessary. CPT Code 90837 was preauthorized, [preauthorization number] therefore it is deemed medically necessary."

Amount in Dispute: $737.48

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on July 30, 2015. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the Division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the Division does not receive the response information within 14 calendar days of the dispute notification, then the Division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 25, 2015 through May 15, 2015	90791, 90837 x 2 and 96151	$737.48	$199.51

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §141.1 sets out the procedures for requesting and setting a Benefit Review Conference.
4. 28 Texas Administrative Code §134.203 sets out the Medical Fee Guideline for Professional Services.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 216 – Based on the findings of a review organization.
   - 5077 – Based on a peer review payment denied because the treatment/service(s) is medically unreasonable/unnecessary.
   - 219 – Based on extent of injury.
   - 5073 – Charge unrelated to the compensable injury.

Issues

1. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.305 and §133.307 for dates of service February 25, 2015 and May 15, 2015?
2. Is the disputed service rendered on February 25, 2015 and May 15, 2015 eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?
3. Did the requestor obtain preauthorization for CPT Code 90837 rendered on April 29, 2015 and May 13, 2015?
4. Is the requestor entitled to reimbursement for CPT Code 90837 rendered on April 29, 2015 and May 13, 2015?

Findings

1. The medical fee dispute referenced above contains unresolved issues of extent-of-injury and medical necessity for date of service February 25, 2015 and unresolved issued of medical necessity for date of service May 15, 2015. The insurance carrier notified the requestor of such issues in its explanation of benefits (EOB) response(s) during the medical bill review process.

   28 Texas Administrative Code §133.305(b) requires that extent-of-injury and medical necessity disputes be resolved prior to the submission of a medical fee dispute for the same services. 28 Texas Administrative Code §133.307(f) (3) (C) provides for dismissal of a medical fee dispute if the request for the medical fee dispute contains an unresolved extent-of-injury dispute for the claim and an unresolved medical necessity dispute for the claim. 28 Texas Administrative Code §133.307(c) (2) (K) provides that a request for a medical fee dispute must contain a copy of each EOB related to the dispute.

   The Division hereby notifies the requestor that for date of service February 25, 2015, the appropriate process to resolve the issue(s) of extent-of-injury including disputes or disagreements among the parties over whether the medical services in dispute were related to the compensable injury, may be found in Chapter 410 of the Texas Labor Code, and 28 Texas Administrative Code §141.1.

   The Division hereby notifies the requestor that for date of service May 15, 2015, the appropriate process for resolution of an unresolved issue of medical necessity requires filing for an independent review to be conducted by an IRO (independent review organization) appropriately licensed by the Texas Department of Insurance, pursuant to 28 Texas Administrative Code §133.308. Information applicable to HEALTH CARE PROVIDERS on how to file for an IRO may be found at http://www.tdi.texas.gov/hmo/iro_requests.html under ***Health Care Providers or their authorized representatives.***

2. 28 Texas Administrative Code §133.307(f) (3) provides that a dismissal is not a final decision by the Texas Department of Insurance, Division of Workers' Compensation ("Division"). The medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of 28 Texas Administrative Code §133.307. 28 Texas Administrative Code §133.307 (c)(1)(B) provides that a request for medical fee dispute resolution may be filed not later than 60 days after a requestor has received the final decision, inclusive of all appeals, on the extent-of-injury dispute.

   The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution. This dismissal is based upon a review of all the evidence presented by the parties in this dispute. Even though not all the evidence was discussed, it was considered. The Division finds that dates of service February 25, 2015 and May 15, 2015 are not eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute for dates of service February 25, 2015 and May 15, 2015. As a result, no amount is ordered.

3. The requestor seeks reimbursement for CPT Code 90837 rendered on April 29, 2015 and May 13, 2015. The insurance carrier denied/reduced the disputed service with denial reason code "216 – Based on the findings of a review organization and 5077 – Based on a peer review payment denied because the treatment/service(s) is medically unreasonable/unnecessary."

   28 Texas Administrative Code §134.600 states in pertinent part, "(p) Non-emergency health care requiring preauthorization includes... (7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or division exempted return-to-work rehabilitation program."

   Review of the preauthorization letter dated March 4, 2015 issued by Old Management documents the following:

Specific Treatment Requested	4 individual psychotherapy visits (90837) between 3/3/15 and 5/2/15.
Determination Date	Wednesday, March 4, 2015
UR Determination	Recommend prospective request for 4 individual psychotherapy visits (90837) between 3/3/15 and 5/2/15 be certified.

28 Texas Administrative Code §134.600 states in pertinent part, "(c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur... (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care..."

The Division finds that the insurance preauthorized disputed date of service April 29, 2015 therefore, the requestor is entitled to reimbursement for this date, pursuant to 28 Texas Administrative Code 134.203 (c). Date of service May 13, 2015 exceeds the preauthorized timeframe noted above. The Division finds that the requestor submitted insufficient documentation to support that an extension of time was requested and approved by the insurance carrier as a result, reimbursement for CPT Code 90837 rendered on May 13, 2015 cannot be recommended.

4. 28 Texas Administrative Code §134.203 states in pertinent part, "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32 (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year..."

   The MAR for CPT Code 90837 rendered on April 29, 2015 is $199.51, therefore this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $199.51.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $199.51 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 22, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.